Health Care System Planning Hospital Sector Workgroup Meeting #1

September 19, 2024

11:30am EDT

Virtual

Attendees:

Aaron Robinson (South County Health), Al Charbonneau (RI Business Group on Health), Alex McKinney (JSI), Alyssa Alvarado (DLT), Angela Sherwin (FCG), Anusha Venkataraman (ONE Central Providence HEZ), Ara Milette (Lifespan), Aryana Huskey (OHHS), Cedric Priebe (HIT Steering Committee/ Lifespan), Charles Estabrook (OHIC), Cheryl Leclair (RIDOH), Cory King (OHIC), Daniel Connors (RI Dept of Housing), Deb Faulkner (FCG), Diana Franchitto (Hope Health), Director Kristin Sousa (OHHS), Director Matthew Weldon (DLT), Elena Nicolella (RIHCA), Fernanda Lopes (RIDOH), Gerry Goulet (Health Policy Analytics LLC), Jane Hayward (RIF, retired), Jessica Brown (FCG), John Fernandez (Lifespan), Julia Harvey for Attorney General Peter Neronha (RIAG), Linda Katz (Healthcare Coalition, retired), Lisa Tomasso (HARI), Lizzy Jones (JSI), Lou Giancola (South County), Lynn Blais (UNAP), Marie Ganim (OHIC, retired), Marti Rosenberg (OHHS), Michael Souza (Landmark), Michael Wagner (CNE), Micheal Dexter (RIDOH), Michelle Sears (NHPRI), Molly McCloskey (OHIC), Mukesh Jain (Brown Medical School), Pat Crowley (AFL-CIO), Rick Brooks (OHHS), Rosemary Costigan (CCRI), Sam Salganik (RIPIN), Secretary Rick Charest (OHHS), Stacy Paterno (RI Medical Society), Susan Jacobsen (Thundermist).

Notes:

Agenda Item	Notes
Welcome & Introductions *Deb Faulkner, Secretary Rick Charest, Alec McKinney, John Fernandez* *Slides 1-2*	• At 11:30 am EDT, **Deb Faulkner** from FCG, opened the meeting by welcoming participants and turning it over to Working Group Chair, Secretary Charest • **Alec McKinney** (JSI) expressed appreciation for the group's engagement, emphasizing that it was crucial for both short- and long-term planning efforts. • **Secretary Charest** highlighted the importance of collaboration in addressing hospital sector issues in Rhode Island. • **John Fernandez** (Lifespan CEO, Co-chair) urged participants to be candid and open-minded during discussions.
Background & Context of the Rhode Island Health Care System Planning (HCSP) Initiative and Hospital Sector Working Group	• Deb Faulkner introduced meeting norms and gave a brief overview of the background materials provided to participants. She underscored the need to stay focused on hospital-specific issues while recognizing the broader impacts across sectors, particularly in primary care and behavioral health.

Deb Faulkner, Slides 3-10	

Working Group Principles Discussion & Feedback
 	
Deb Faulkner, Slide 11
	• Deb Faulkner introduced Principles to guide the process and products of the Hospital Sector Working Group to ensure the overarching goals set by the RI Health Care System Planning Initiative are achieved and opened the floor for member input.
	
	Discussion & Feedback
	• Marie recommended *Principle 1* be updated to "*ensure* equitable, high quality, affordable access to healthcare for all individuals and communities" noting we also have to ensure that we're not further burdening providers or diminishing the patient experience in any way
	• Anusha recommended *Principles 2 & 3* emphasize a lens on root cause, noting that we don't want "quick fixes" to replicate existing challenges and inequities
	• Aaron requested for the group to agree to the fact that there is a gap in critical information to inform the strategic planning process, and to identify and agree on the specific data that is missing.
	• Aaron referenced *Principle 3. Data Informed Decisions* and noted that to be data informed is important but to have data governance on that data is even more important
	  ○ Aaron added that transparency into the data/measures used, for *Principle 3. Data Informed Decisions* is needed as well as committee agreement on what's included, what's excluded, and if the data is reliable.
	• Regarding a portion of *Principle 5. Collectively aim to keep healthcare revenues in the healthcare sector*
	  ○ Participants largely asked for this principle to be better defined
	  ○ Sam recommended updated to something like "Where additional federal funding is identified, do not use that to displace existing State funding"
	  ○ Cory noted the language used seemed to implicate participation of for-profit entities, particularly distribution of profits to shareholders, and recommended refining the language.
	  ○ Susan asked that the group better define "healthcare sector" especially as SDOH is "medicalized".
	  ○ Al stated that raising hospital taxes, as a form of healthcare revenue, has an impact on commercial premiums – noting that not all agree on this point and that that using hospital taxes as a method to generate revenue should be a point of discussion for the working group.
	• Lou added that we also can't make the business climate worse and cited John Fernandez as always saying, the long-term solution has to include population growth which can only occur with more jobs.
	  ○ Pat highlighted that those jobs have to be good jobs that are paid well with decent benefits, and most "business climate" rankings give negative points for having strong worker protections.

Q&A on Appendix #1. RI Hospital Sector Starting Point & National Landscape Review (slides 29-49 of the accompanying deck)
 	
Deb Faulkner, Slide 12
	• Deb Faulkner referenced Appendix #1 *RI Hospital Sector Starting Point & National Landscape Review* (slides 29-49 of the accompanying deck), provided to the group as pre-read material and asked the group to raise any questions or concerns on this material.
	
	Discussion & Feedback
	• Linda asked that the local integration of physician practices into the hospital networks overtime be documented, to give us a picture of where we were vs where we are now and the impact.
	• Al noted the need for a good drill down on hospital expenses and cited that he will be releasing some of that data to hospitals soon and can share with the group. The expense analysis has been developed in cooperation with faculty from the Business Analytics department at URI.
	  ○ Linda added that information about direct patient care costs and administrative costs over time would also be helpful.
	• Ara highlighted that there is a lot of "noise" in the RN workforce data. Now that the nurse licensure compact is live (eff 1/1/24). Noting that moving forward, we should expect to see significantly fewer total licensed RNs, and a more accurate reflection of the true nursing workforce in RI.
	• Stacy asked for data on Medicare Advantage Rates
	  ○ Marie noted that federal pre-emption limits state oversight of Medicare Advantage plans, referring to the Commissioner to address this.
	• Sam applauded the background data stating that with this (and the RI Foundation report), he's seen some good data on unit prices in commercial and Medicare.
	  ○ He added that seeing Medicaid reimbursement rates in comparison to other States, and/or to commercial/Medicare, and/or trended over time would be helpful.
	• Al requested additional information be shared on the national overall direction of the hospital industry for context.
	  ○ Deb responded that this information can be brought forward in the next meeting, noting that national trends are very consistent with local trends.

Confirm Draft Problem Statements & Priorities *Deb Faulkner, Slides 13-17*	• Deb Faulkner introduced draft Priority A and B problem areas (slides 15-16 of the accompanying deck) and asked working group participants to discuss their 1st priority problem statements and whether they were reflected appropriately in the meeting materials in small groups. • Working Group participants spent 7 minutes in small group breakout rooms – note, discussion during these breakouts was not captured although some participants remained in the main meeting room and discussion in this group was documented and is included in the Problems & Priorities Discussion and Feedback summarized below. • Working Group participants returned from their breakout rooms and Deb Faulkner opened the floor for discussion on problem statements and priorities. **Discussion & Feedback (from those that remained in the main meeting room during breakouts)**

- Stacy stated that there's a percentage of Rhode Islanders that are going of out of state for care and asked about this comes into this discussion, noting that we need to better understand the outmigration of services.
- Stacy added that hospitals in RI are disproportionately impacted by Problem Area #3 *Limitations in Investment & Infrastructure* because of the independent local insurers we have in RI (NHPRI & BCBSRI) – they are required to have their own infrastructure which impacts costs and operations.
    - Mike Wagner agreed, adding that NHPRI & BCBSRI are relatively small insurers which limits their ability to invest in systems that actually help hospitals from a data perspective.
- Mike Souza highlighted concerns about the Certificate of Need (CON) process, noting that its troubling that every application gets approved. Mike recommended CON applications only be processed if they align with the long term needs of the state.
    - Mike emphasized that hospitals need the infrastructure for labs, radiology, surgery, endo, etc to operate and that as more small scale facilities open up - offering select services - it dilutes hospital volume, increases costs, and revenues suffer.
    - Stacy added that conditions set on CON approvals lack substance, citing a lot of past CON approvals that were once non-profit and local have now changed ownership and been transitioned to for-profit or out of state entities.

Discussion & Feedback (after all participants returned from their breakout rooms)

- Aaron recommended Problem Area #1 *Lack of Statewide Health System Planning* should be modified to focus more on a statewide framework for data, from which plans can be made by people doing the work.
    - Linda advised the Problem Area #1 be changed to emphasize lack of oversight and ongoing fact based review.
    - Sam strongly agreed, regarding consistent availability of reliable data being more important than "planning"
- Aaron added that he would move Problem Area #2 *Reimbursement Not Keeping Pace with Rising Costs* to #1 and would add *payer behaviors* as a key component to this problem area (e.g., denials, ongoing arbitrary changes). Aaron noted these behaviors undermine not only the inadequate reimbursement hospitals already have, but to the extent they increase will make an already bad problem worse.
    - John noted that this problem is not just about hospital reimbursement, it's about our doctors as well.
    - Cory agreed that the physician piece must be integral to this conversation, especially given the growing footprint of hospital/health system ownership of physician practices.
    - Deb responded that this concern about payer behaviors, specifically for Medicare Advantage, was heard loud and clear from all hospitals FCG interviewed.
- Anusha appreciated that *limited focus on statewide health equity* was included in Problem Area #1 and identified that lack of coordination across the continuum of care, including with

	community organizations with social service providers, and others that can ensure people are accessing preventative care felt like it was missing from the list of problems. ● Julia highlighted a recommendation she attributed to Susan during the breakout, that we need to improve usability and public access to any data that is collected and analyzed (so it is available to all providers, partners, and researchers, not just state agencies).
Introduce & Develop Preliminary Strategies & Opportunities *Deb Faulkner* *Slides 18-25*	● Deb Faulkner introduced preliminary strategies and opportunities, focusing on those that could potentially address Priority A problem areas (slides 20-22 of the accompanying deck) and asked working group participants to discuss the #1 strategy they would like this working group to consider and whether it is appropriately captured and defined the meeting materials in small groups. ● Working Group participants spent 7 minutes in small group breakout rooms – note, discussion during these breakouts was not captured although some participants remained in the main meeting room and discussion in this group was documented and is included in the Strategy and Opportunity Discussion & Feedback summarized below. ● Working Group participants returned from their breakout rooms and Deb Faulkner opened the floor for discussion on problem statements and priorities. **Discussion & Feedback (from those that remained in the main meeting room during breakouts)** ● Gerry agreed with materials shared, that one of the first priorities for the working group should be getting the data and improving hospital fiscal transparency. ● Gerry asked for clarification on strategy #10 to *Restructure Oversight of Mergers and Hospital Conversion* regarding the pathway and intent to implement guardrails on private equity (PE) investments and to more substantially restrict transitions from nonprofit to for profit. Gerry questioned if this would be accomplished through the Change of Effective Control (CEC) process and cautioned that this process appears to be enough of a hurdle. ○ Gerry added that he doesn't have a problem going with nonprofit hospitals only as long as the state has a mechanism to look at for profit hospital data as well. ○ Marie recommended that the group try to access historic information on the results of hospital conversions – advising that this topic warrants further group discussion supported by data. ○ Gerry questioned why there was a separate solution geared toward reducing regulatory restrictions on mergers and out of state alignment, because that's essentially how private equity investment guardrails are implemented. ● Marie raised the discussion of capital for investments in infrastructure and technology (Problem Area #3) and options to access it, noting that bonds need to be paid back which is challenging and asked if Brown University could continue to be an alternate source. ○ Lou added that if the investment doesn't save money, then is doesn't have a return on investment (ROI), and it doesn't make sense to have a bond regardless of who is funding it. Can hospitals define strategies that would result in a return? If not, it comes back to focusing on administrative costs and back-office funds, etc. **Discussion & Feedback (after all participants returned from their breakout rooms)**

- Secretary Charest acknowledged that many people don't like funding from private equity but shared that he thinks PE can be controlled to prevent unintended consequences. Secretary Charest noted that RI hospitals have so much deferred maintenance and unfunded depreciation that it's unlikely to be solved with bonds alone, suggesting other sources of equity will be needed.
    - Julia raised that what we currently call private equity continues to evolve and often remains one step ahead of regulators. So any solutions to address the negative impacts of PE in health care need to focus heavily on the harms we're trying to prevent, paired with flexibility to ensure that any statutory or regulatory reform can be adequately leveraged to address new and changing actors.
- Cory offered his support for hospital fiscal transparency and performance monitoring, noting that building this capacity in state government is needed now and was part of recommendation #4 made in OHIC's Annual Report: Health Care Spending and Quality in Rhode Island, 2024.
    - Cory added that RI is flying blind as a state without comprehensive data on hospital financial performance, revenues, costs, and quality performance. Notice requirements and regulatory review of physician group practice acquisitions is needed as well.
    - Rick agreed, stating there's transparency/reporting requirements, but then there's enforcement!
    - Sam expanded on this point, advocating for capacity and expertise within State government (or contracted partners) to actually use the data that gets submitted - review it, understand it, disseminate it, etc.
- Susan noted the importance of including health equity in the discussion, identifying that while it is part of the problem statements it feels missing from the solutions. Susan mentioned the national focus on frameworks for health equity, such as those developed by NCQA and questioned if those could be leveraged to support hospitals and link to community health needs assessments and community benefits.
    - Susan recommended that a focus on generating outcomes that reducing disparities and health equity focused decision making be better reflected in the working groups opportunities, noting these may or may not link to global payments.
    - Anusha agreed, and recommended extending the hospital learning collaborative, Strategy #5, to sharing learnings with communities - for instance, assisting with Medicaid billing, etc.
- John added that payment inequities for Medicaid and uninsured patients must be addressed as a core issue of health equity.
    - Susan agreed that we get what we pay for (and what we don't pay for).
- Stacy highlighted that hospital systems in RI, even Lifespan and Care New England are relatively small on a national scale and require significant resources to build administrative infrastructure, taking resources away from other priorities.
    - Stacy added that Mike Souza had shared Landmark was able to have a decent profit margin because of the back-end infrastructure available.

	• Pat advocated for the group not to lose sight of the important bottom-up solutions identified in the meeting materials, especially those addressing workforce issues, noting that much of the conversation had been focus on big picture top-down solutions.
	• Aaron advocated for greater emphasis on the issue of physician adequacy, sharing that the number one complaint he hears is that folks can't get in to see a primary care physician or specialists and this is why ED utilization is higher.
	  ○ Aaron added that physician adequacy/access needs to be measured, noting differing opinions on if RI has an access issue or not.
	  ○ Aaron referred back to John's comment on payment inequities for Medicaid, and highlighted that if providers aren't taking Medicaid because it doesn't pay enough, or if programs and services are cut because hospitals can't afford them, or hospitals doesn't have enough doctors and nurses – these issues all disproportionately impact the most marginalized populations in RI, which is why access needs to be a key focus of this group.
	• Deb agreed that lack of access to primary care physicians and specialists came up in many conversations with working group members, noting many of the solutions offered are identified on the "other working group" section for the Primary Care Working Group specifically, but acknowledged the issue remains a key driver of hospital sector specific problems.
	  ○ Aaron responded that most physicians are employed through hospitals.
	  ○ Cory agreed that the working group needs to include the physician perspective with respect to rate adequacy and supply because the audited financial statements that break out the physician group practices, show that they're losing money there and that's part of the story. Cory shared a link to the last comprehensive hospital payment variation study with data from almost 15 years ago. Appendices here: https://ohic.ri.gov/sites/g/files/xkgbur736/files/documents/Hospital-Payment-Study-Appendices-General-Dec-2012.pdf
	  ■ Sam commented that the OHIC hospital payment variation study (yes, VERY outdated) said that Medicaid actually paid higher rates than Medicare, above cost, and higher than national averages. May not be true anymore, but it was also surprising at the time...
	  ■ Anusha and Stacy chimed in to advocate for taking a broader health system view and incorporating the role of physicians into the conversation.
	  ○ Deb agreed and pointed to solutions #25 and #27 in the meeting materials which are focused on conducting a physician/specialist rate study and addressing rate inadequacy accordingly. Deb acknowledged this piece was initially considered secondary to a hospital rate study but given the driving force in hospital financials the studies may need to happen in parallel if resources are available.
	• No further questions or comments were provided by working group participants

Summary of data/research needs identified by participants	• **Any local or national publicly available data/research regarding:** ○ Outmigration of services (e.g., percent of Rhode Islanders leaving the state for services by service type)

	○ Provider/physician access ○ Cost and quality outcomes related to hospital mergers, consolidations, and private equity control ○ The results of hospital conversions - would be helpful to inform potential changes to the hospital conversion act ○ The integration of physician practices into the hospital networks overtime - to give a picture of where we were vs where we are now and the impact. ○ Overall direction of the hospital industry for context setting (i.e., difference between nonprofits and for profit, small versus large, volumes, down parameters, service mix changes, etc.) ○ Changes in payment models, and federal involvement ● **Future Studies Needed** ○ Study of Medicaid reimbursement rates in comparison to other states, and/or to commercial/Medicare, trended over time ○ Medicare Advantage rates ○ Hospital costs: direct patient care costs and administrative costs, overtime
Meeting Close	
Next Steps *Deb Faulkner* *Slide 26-27*	● Deb Faulkner reviewed next steps, including that ○ 1) FCG will circulate refined problem statements and strategies along with a survey on priority solutions to be completed by workgroup participants, and ○ 2) the next meeting is scheduled for October 17th 2:00-3:30pm ET and will focus on recommendations for action and strategic opportunities. Materials will be circulated in advance.